Meeting Summary

eHealth Technical Working Group
December 15, 2009 10:30-11:30AM

Please refer to the meeting slides for additional information.

High-Level Issues from Last Meeting (Slide 3)

During the course of the TWG meeting on 12/8, some significant high-level issues were raised, including:

- Whether the goals for the technical architecture in the near term should just enable meaningful use for the maximum number of eligible providers, or also promote additional improvement goals for the health care system in California, beyond the specific meaningful use functions.
- The cost/benefit of H.I.E. infrastructure and services required for "pushing" data versus "pulling" data.
- Assumptions regarding the necessity of a Health Information Organization to enable HIE for meaningful use – absolutely needed or just one way to achieve HIE?

HIE Cooperative Agreement Program (Slides 5-13)

To ground further discussion of these issues, the funding opportunity announcement (FOA) of the HIE Cooperative Agreement Program (the federal funding mechanism by which California's HIE operational plan will be supported) was reviewed.

Definitions (Slide 6)

The following terms were reviewed and the group was requested to adhere to their definitions as stated in the FOA to avoid confusion:

1. Health Information Exchange (HIE): the electronic movement of health-related information among organizations according to nationally recognized standards. Here, the term is being used in the verb sense and does not refer to an organization.
2. Health Information Organization (HIO): an organization that oversees and governs the exchange of health-related information among organizations]
3. Regional Health Information Organization (RHIO): an HIO that brings together health care stakeholders within a defined geographic region and governs health information exchange.

Role of Meaningful Use (Slide 7):

The FOA clearly specifies that the state's HIE planning efforts center around meaningful use. In particular, it is stated that the information exchange requirements for meaningful use will inform a strategic framework for the HIE Cooperative Agreement Program. Goals, objectives, and corresponding measures of meaningful use that require HIE will be the reference point for states and/or SDEs in their HIE infrastructure development plans.

Roles of Government and Private Sector (Slide 8):

The FOA mentions that state government, federal government, and the private sector will all play important roles in advancing HIE. The role of the state is to develop and implement Strategic and Operational Plans that will result in actions that ensure the adoption of HIE to enable providers to meet HIE meaningful use criteria. Among others, the state will be expected to (1) develop state level directories and enable technical services for HIE, (2) remove barriers and create enables for HIE, and (3) convene health care stakeholders to ensure trust in and support for a statewide approach to HIE.

Pathway to HIE (Slide 9):

Because meaningful use criteria will become more stringent over time, ONC recommends that a pathway for realizing statewide HIE be considered in a series of stages consistent with the statutory requirements for meaningful use.

Required Performance Measures and Reporting (Slides 10-11):

The HIE Cooperative Agreement Program specifies certain reporting requirements and performance measures. The state will be required to report on the following with respect to the HIE technical architecture:

- Development of a state HIE architecture and readiness of the architecture for implementation
- Integration with state-specific Medicaid management information systems
- Integration of regional HIE efforts
- Proportion of healthcare providers in the state who are able to send/receive electronic health information using the statewide HIE technical infrastructure

Performance measures that the state will need to submit once the implementation phase begins include:

- Percent of providers participating in HIE services enabled by statewide directories or shared services
- Percent of pharmacies actively supporting e-prescribing and refill requests
- Percent of clinical laboratories actively supporting electronic ordering and results reporting

Future performance measures will be specified to measure the extent of meaningful use in areas such as providers' use of e-prescribing, exchange of clinical summaries, immunization, quality, public health reporting, and eligibility checking.

Anthony Stever asked about the timing of performance measurement in relation to the state receiving funding, to which Walter clarified that of the $38.8 million requested, most would be disbursed within the first two years of the program, with the disbursement of the remaining funds contingent upon performance in the first two years. Anthony also pointed out that collection of the performance data would be challenging particularly with respect to accurate calculation of the denominator. Walter concurred, mentioning that while outside the scope of this work group, the state would need to come up with a way to report these measures.

Detailed Guidance for Technical Infrastructure Section of Operational Plan (Slide 13)

The state's Operational Plan will need to describe:

- Efforts to become consistent with HHS adopted interoperability standards and any certification requirements.
- How the technical architecture will accommodate the requirements to ensure statewide availability of HIE among stakeholders.
- How the architecture will align with NHIN core services and specifications, if the state plans on exchanging information with federal health care providers.
- Technical solutions that will be used to develop HIE capacity and particularly enable meaningful use criteria for 2011. If the state plans to participate in NHIN, plans must specify how they will be compliant with HHS adopted standards and implementation specifications.

Project Charter (Slide 14)

Relevant aspects of the eHealth Technical Committee project charter were briefly highlighted for the benefit of participants to illustrate the consistency with which the charter reflects the requirements of the HIE Cooperative Agreement Program. Principles in the charter include the foundational nature of meaningful use for the set of services to be developed, the broad constituency of HIE services, and the prioritization of shared services that are critical to meaningful use.

Meaningful Use and Design Goals of Statewide HIE Architecture (Slide 16)

With the FOA language just reviewed in mind, participants revisited the issue of whether to design the technical architecture to meet the goals of meaningful use or to accomplish other healthcare-related goals. Walter asked whether there was agreement within the group around making the design goal to enable meaningful use as opposed to other goals. Jeff Evoy suggested that at least initially, enabling meaningful use was clearly what the architecture needed to accomplish. There was general agreement among the group with regard to this principle. Jeff stated that given this new understanding he would revise the e-prescribing HIE shared services document to better fit the goals of meeting meaningful use.

Push vs. Pull Services:

The necessity of providing push vs. pull services to meet various aspects of meaningful use was revisited. Dave Handren asked if it mattered whether the information was available via push vs. pull, as long as it was available. Rim Cothren observed that push vs. pull is dependent on workflow. There will be instances where the parties who need to receive information will not be known beforehand, which would necessitate supporting a pull. An example of this would be a pull of patient data in response to an unforeseen emergency room visit. On the other hand, there are cases where a push is necessary because the recipient of that information does not know that the information has been generated and therefore needs to be requested. An example of this would be updating a physician on new lab results for a patient, which requires a push. Thus, the question is, under which scenarios will it be important to support both push and pull, and when will it be possible to support just one or the other to meet meaningful use?

Several members raised the point that during the design process, it would be important to identify the functionality that would be necessary to eventually support the workflow around the entire transaction, as opposed to simply trying to meet the bare minimum of short-term meaningful use. It was agreed upon as a general principle to focus on the 2011 goals for meaningful use but to include "placeholders" for additional functionality that, while a lower priority for immediate implementation, should be supported in the medium-to-long term.

The group reviewed the meaningful use cases on Slide 16 for push vs. pull requirements.

- E-prescribing: push (transmit prescriptions electronically). There was a question about whether prescription fill history (which would require a pull) was part of meaningful use criteria in 2011.
- E-lab: push or pull (incorporate lab results into EHR), depending on the situation
- Clinical summary sharing: push or pull ("exchange" key clinical information electronically)
- Population health: push or pull (generating lists of patients by specific conditions may entail both pushing specific encounter or test result data to a registry, or pulling information from all available sources to populate a registry)
- Immunization registries: push (submit electronic data to immunization registries). In 2013, providers will need to be able to also access data in immunization registries. Eileen Moscaritolo suggested that in general, there would need to be both push and pull functionality. At times public health agencies may need to know which patients received a vaccine in the case of a drug recall, for example. Also, payers or providers would want to query registries for immunization data, such as in the case of school nurses pulling immunization data for children or payers needing to pull data for quality reporting purposes.
- Patient-centered care: push ("provide patients with electronic copies of health data"), pull ("provide patients with access to their health data")
- Public health reporting: push (provide electronic syndromic surveillance data to public health). In 2013, providers will also need to receive alerts from public health agencies, although this could theoretically be accomplished without HIE, per se.
- Quality reporting: push (submitting quality data), possibly pull (gathering data from different sources to calculate a measure)

A question was raised about the above cases and what assumptions were being made with respect to HIE, since in some instances it appeared as if there might be overlap between the role of an HIO and EHR application functionality. Walter clarified that the group was being asked identify necessary shared services for health information *exchange* needed to meet the meaningful use cases, without any assumption as to whether and EHR or an HIO would be providing the *application* functionality to meet the use case (e.g., the ability to formulate an electronic prescription or view an electronic lab result).

Tim Andrews raised the point that from a technical perspective, it was enough to determine whether a push was needed, push is a functional superset of pull. Walter stated that in his experience with other HIE-related projects, there arise additional issues of privacy, legal liability, and consent with pull that are not as prominent with push. Eileen mentioned that there are in fact consent issues with both push and

pull, and that the stringency of California privacy laws supersedes HIPAA. One law, for example protects certain types of data from being shared without consent (e.g., behavioral health, substance abuse, HIV), and another law restricts the sharing of data between health plans without consent. Dave Handren noted that data anonymization plays a role in public health reporting.

HIE Coverage for Meaningful Use in California (Slide 17)

One way to conceptualize the goal of enabling HIE for meaningful use in California is to break out the goal by meaningful use function, type of organization, and geographical region. For a given meaningful use function (e.g., e-prescribing), certain types of organizations (e.g., chain pharmacies and large ambulatory practices) may already be capable of exchanging the necessary health information throughout the state, while other organization types (e.g., small ambulatory practices) may have HIE coverage in limited regions or may not have HIE capabilities at all regardless of region. In certain regions, RHIOs may be able to provide all necessary HIE services across meaningful use functions and/or organizations. The goal of the technical architecture to be designed and implemented is to fill the gaps within the state wherever existing HIE services are insufficient to meet meaningful use goals.

Example of HIE Coverage for E-Prescribing (Slide 18)

As an illustration of the above approach, Walter shared data on the SureScripts network. Surescripts' penetration is 74% of the state's retail pharmacies overall, but the percentage varies by locale and ranges from 68-100% depending on the MSA. The vast majority of covered pharmacies are large pharmacy chains, while many independent or mail order pharmacies remain uncovered. Since SureScripts can provide a means to meet the requirement for meaningful use, the HIE "coverage gap" on the pharmacy side could be described as those pharmacies not covered by SureScripts. In this case, the state could further enable meaningful use simply by encouraging uncovered pharmacies to connect to e-prescribing networks (which may or may not even require the implementation of new technical infrastructure, given that at least one such network already exists). Determining an appropriate solution might require coordination with state policy planning activities.

Walter suggested as a straw man that the technical architecture for e-prescribing leverage SureScripts. Tim Andrews pointed out that relying on SureScripts had the issues of limited coverage of independent pharmacies, and the requirement that providers have an EHR capable of connecting to SureScripts. Dave Handren explained that Long Beach Network for Health will have connectivity to SureScripts, and will give providers access to an e-prescribing application so that providers can connect to SureScripts without an EHR. Tim Andrews noted that this approach represented a different choice that was architecturally distinct from simply declaring that connecting to SureScripts through an EHR would be the way to achieve the e-prescribing HIE goal. In the former case, the SureScripts network would be integrated into the statewide approach to HIE through one or more HIOs such that a provider accessing the state's HIE services would have access to SureScripts. This approach would allow more flexibility in terms of the application platforms that a provider could use to connect to SureScripts. It was agreed that such architectural choices would require more discussion in the future.

A question was asked about whether qualification for meaningful use explicitly required the use of an EHR (versus performing meaningful use functions via an HIO, for example). The answer to this appears unclear. Rim noted that the original language in ARRA made reference to certified EHR use, and that some criteria for meaningful use have to do with clinical documentation in an EHR. Dave Handren responded that it would certainly be possible for providers to use a certified EHR but have a separate tool for e-prescribing. Rim agreed, stating that the final rule may well indicate that the use of multiple applications is an acceptable method of meeting meaningful use.

Other Meaningful Use Scenarios (Slides 19-21):

Due to time constraints, work group members were asked to review the slides in preparation for continued discussion at the next meeting.

Foundational Shared Services (Slide 22):

Walter briefly introduced the concept of foundational services for HIE. Such services are fundamental to HIE across arbitrary entities, although they may not necessarily apply within HIOs. Examples of potential services include directories, authentication services, identity reconciliation, and data coding standards. Discussion around these services will take place at the next meeting.

Next Steps:

- The next meeting will be 12/22 11am-12:30pm. The group will plan to continue discussion on how to provide HIE services within the meaningful use scenarios (e-lab, clinical data sharing, etc.), as well as what foundational shared services will be needed for HIE.
- TWG members are encouraged to use the discussion list to share ideas.

Summary of Key Questions/Issues/Decision Points:

- As a general principle, it was agreed to focus design goals on meeting the 2011 goals for meaningful use, but to also include “placeholders” for additional functionality that, while a lower priority for immediate implementation, should be supported in the medium-to-long term.
- To what extent will providers be required to use EHRs versus other applications in order to meet meaningful use criteria?

Members Present

Name	Organization
Jane Brown	Nautilus Healthcare Management Group
Scott Cebula	Independent
Scott Christman	CA Dept. of Public Health
Robert("Rim") Cothren	Cognosante, Inc.
Jeff Evoy	Sharp Community Medical Group
Jonah Frohlich	California Health and Human Services Agency
Larry Hammond	CA Dept. of Health Care Services
Dave Handren	Long Beach Network for Health
Daniel Haun	Adventist
Alex Khayat	Huntington Hospital
Lee Mosbrucker	CA Office of the Chief Information Officer
Eileen Moscaritolo	CalOptima
Orlando Portale	Palomar Pomerado Health District
Anthony Stever	AWS Consulting / Redwood MedNet
Jim Thornton	MemorialCare
Ben Word	CA Dept. of Health Care Services

Staff Present

Name
Walter Sujansky
Tim Andrews
Peter Hung